STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	11/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EXCEPTIONAL LIVING CENTER OF BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 28, 29, 30, 31, and November 1, and 4, 2019. Facility number: 000514 Provider number: 155503 AIM number: 100266800 Census Bed Type: SNF/NF: 52 Residential: 28 Total: 80 Census Payor Type: Medicaid: 44 Other: 36 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 12, 2019.	F 0000	Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet State and Federal requirements.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record	F 0558	It is the Policy of Exceptional Living Center of Brazil to ensure	12/04/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	review, the facility failed to ensure individual's needs and preferences were provided related to ensuring a room light pull cord was within reach for 1 of 1 resident reviewed for accommodation of needs (Resident 17). Findings include: On 10/28/19 at 10:48 a.m., Resident 17 was observed in her room, lying in bed in the dark. The resident requested her light to be turned on, because she was not able to reach the over the bed light pull cord. On 10/31/19 at 2:36 p.m., Resident 17 was observed in her room, lying in bed in the dark, and asked the Director of Nursing (DON) to turn on her room light. Resident 17 indicated she was not able to turn on or turn off her light, because it was out of reach. The DON told Resident 17 staff would fix the light pull cord so that the pull cord was within reach and the resident could turn on and off her room light. On 10/31/19 at 2:45 p.m., the DON indicated, she had not realized Resident 17 could not turn on or off her room light. The DON had always just asked the resident if she wanted her light on or off and did it for her. The resident's pull cord for the light should have been within the resident's reach. Resident 17's record was reviewed on 10/30/19 at 11:38 a.m. Diagnoses included, but were not limited to, rheumatoid arthritis without rheumatoid factor, unspecified hand (RA) and dementia (a group of thinking and social symptoms that interferes with daily functioning). A quarterly Minimum Data Set (MDS) assessment, dated 8/8/19, indicated, the resident		Resident individual needs and preferences are provided related to ensuring a room light pull cords are within the reach of the resident. Step 1 Resident 17 was assessed by Occupational Therapy for proper bedside lighting. Resident 17's Care Plan was reviewed and updated as appropriate. Step 2 Current facility residents were reviewed by the Clinical Interdisciplinary Team to ensure each resident was able to reach his/her room light pull cord as appropriate. Care Plans were reviewed and updated as appropriate. Step 3 Licensed Nurses, Certified Nursing Assistants, Housekeepers, Therapy, Maintenance and Department Managers were re-educated to notify the Clinical Management Team if a resident is unable to turn on/off his/her own light (over-bed light) if the resident voices he/she would like to be able to turn on/off his/her own light. Step 4 The Executive Director or designee will perform Quality Assurance Performance Improvement via interviews and visual observance to ensure residents are able to turn on/off his/her own light (over-bed light)	

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	had a severe cognitive impairment and required extensive assistance of one to two staff members for bed mobility and transfers. On 11/1/19 at 10:18 a.m., the DON provided and identified as a current facility policy, dated 11/28/17, titled "Resident Rights," which indicated, "...Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-...A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belonging to the extent possible...Adequate and comfortable lighting levels in all areas...." 3.1-3(v)(1)		per the residents wishes 3-5 times weekly for four weeks then weekly for four weeks, then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept			

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	or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on record review and interview, the facility failed to ensure a the code status matched the physician's order and the Indiana Physician's Orders For Scope of Treatment (POST) document, for 1 of 24 resident's code status reviewed (Resident 42). Findings include: During the initial pool record review on 10/29/19 at 9:34 a.m., Resident 42's face sheet indicated the resident's code status was do not resuscitate (DNR). A physician's order, dated 8/31/19, indicated the resident's code status was a full code (indicates that a person elects to receive	F 0578	It is the Policy of Exceptional Living Center of Brazil to ensure the code status matches the physician's order and the Indiana Physician's Orders for Scope of Treatment (POST) document. Step 1 Resident 42's Face Sheet was corrected at the time of the survey to match the Physician's Order and the POST. LPN 2 was re-educated to review the POST and the Physician's Order if a resident is coding (heart not beating) to determine the code status of the resident.	12/04/2019

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	CPR if their heart stops beating). Resident 42's record was reviewed on 10/31/19 at 11:15 a.m. A POST document, dated 9/19/19, indicated the resident's desire was to have CPR attempted. During an interview, on 10/31/19 at 11:20 a.m., Licensed Practical Nurse (LPN) 2 indicated if a resident was coding (heart was not beating), the staff would look on the resident's face sheet in the electronic record to determine the desired code status. This would determine whether CPR would be initiated or not. During an interview, on 10/31/19 at 11:30 a.m., the Executive Director (ED) indicated that the code status for Resident 42, did not match up with the code status physician's order and the resident's POST documents. There was no facility policy related to resident code status. The facility would follow the regulations. 3.1-4(f)(7)		Step 2 Current facility residents Face Sheets, POST's and Physician's Orders were reviewed to ensure all areas matched. No additional areas of concern were identified. The Social Services Director will conduct a monthly review of current facility residents to ensure the Face Sheet, POST and Physician's Order for the resident's code status are accurate. Step 3 The Clinical Interdisciplinary Team and Licensed Nurses were re-educated that the code status of a resident much match in each area of the Resident's Medical Record. This includes the Face Sheet, the POST and the Physician's order. Additional training with an emphasis on when the licensed nurse reviews the medical record or receive an order to change the code status of a resident, the Licensed Nurse must ensure each area matches. Re-education also included for the licensed nurse to review the POST and the Physician's Order if a resident is coding (heart not beating) to determine the code status of the resident. Step 4 The Director of Nursing or designee will perform Quality Assurance Review five residents to ensure the Face Sheet, POST and Physician's Order are accurate	

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			weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

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	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to ensure the resident's family was notified when a physician ordered a new medication to the resident's medication regimen due to significant weight loss (Resident 39). Findings include: Resident 39's record was reviewed on 11/1/19 at 9:40 a.m. Diagnosis on the resident's profile included, but were not limited to, unspecified dementia without behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 9/30/19, indicated the resident had severe cognitive impairment, required extensive assistance of one person for eating, and had a significant weight loss, but was not on a physician prescribed weight loss regimen.	F 0580	It is the Policy of Exceptional Living Center of Brazil to ensure the resident and/or the Responsible Party is notified when a physician orders a new medication to the resident's medication regimen. Step 1 Resident 39's family has been notified of the medication changes. Step 2 Current facility residents Physician's Orders for the past 30 days were reviewed to ensure the resident's responsible party was notified of medication changes. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review	12/04/2019

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	A nutritional status care plan, initiated on 6/18/18 and last revised on 10/25/19, indicated the resident was at risk for potential alteration of nutrition and/or weight status with significant weight loss. Interventions included, but were not limited to, provide diet as ordered, assist resident as needed for eating/drinking, provide supplement as ordered, medications as ordered, honor preferences and offer alternate items if consumption is poor, and obtain and evaluate weights as ordered/per policy, notify physician, dietitian, and family of any significant changes. A physician's order, dated 10/30/19, indicated Remeron tablet (antidepressant medication used as an appetite stimulant) 15 milligrams (mg) daily for anorexia with weight loss. The record lacked documentation Resident 39's family had been notified of the new medication, Remeron, had been added to the resident's medication regimen. During a telephone interview, on 11/1/19 at 1:56 p.m., Resident 39's family indicated, she had not spoken to staff at the facility about the resident's weight loss, since the care plan meeting on 10/21/19. The family member was concerned about the resident's weight loss and the pureed diet. She was wasting away. On 11/01/19 at 3:04 p.m., the Staff Development Coordinator (SDC) indicated, the family should have been notified that a new medication, Remeron, was added the resident's medication regimen. It just got missed. On 11/1/19 at 3:08 p.m., the SDC provided and identified as a current facility policy, dated		new Physician's Orders with medication changes to ensure the resident and/or the Responsible Party has been notified of the medication change; if this is not documented, the notification will be completed. Step 3 Licensed Nurses were re-educated to ensure the Responsible Party is notified of medication changes and to document the notification in the medical record. Step 4 The Director of Nursing or designee will perform Quality Assurance Review to ensure the Responsible Party is notified of medication changes 3-5 times weekly for four weeks then weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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	12/26/16, titled "Documentation in the Clinical Record," which indicated, "Purpose: ...Guidelines for documentation of assessment of a resident and changes in the resident's medical or mental condition in the resident's medical record...Procedure: ...Documentation of procedures and treatments may include...Notification of family...." 3.1-5(a)(3)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who			

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	becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is			

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	necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to ensure information was provided to the hospital with a hospitalization for 1 of 2 residents reviewed for hospitalization (Resident 34). Findings include: Resident 34's record was reviewed on 10/31/19 at 10:28 a.m. An annual Minimum Data Set (MDS) assessment, dated 9/19/19, indicated the resident was cognitively intact. Diagnoses on the resident's profile included, but were not limited to, chronic diastolic congestive heart failure (part of the heart becomes thick and stiff, making the heart unable to pump enough blood to the body). A nursing note, dated 9/7/19, indicated the Certified Nursing Assistant (CNA) reported to the	F 0622	It is the Policy of Exceptional Living Center of Brazil to ensure information is provided to the hospital when a resident is sent to the hospital. Step 1 Resident 34 has returned to the facility and remains stable at this time. Step 2 The facility will ensure that a Resident Transfer form is sent with the resident to the hospital. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review residents who were sent to the hospital to ensure a Resident Transfer form was sent to the hospital; areas of concern will be addressed immediately.	12/04/2019

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	nurse the resident had increased shortness of breath. The nurse practitioner (NP) was notified and ordered the resident sent to the emergency room (ER). The note lacked documentation information was conveyed to the receiving hospital with the transfer. Census information indicated the resident returned to the facility on 9/11/19. During an interview, on 11/1/19 at 10:22 a.m., the Director of Nursing (DON) indicated she was unable to find documentation clinical information was communicated to the receiving hospital with the transfer to the hospital in September 2019. When a resident was transferred to the hospital, a report should have been called to the hospital. On 11/1/19 at 10:22 a.m., the DON provided a document titled, "Transfer and Discharge Requirements," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To specify the limited conditions under which a skilled nursing facility or nursing facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making the documentation...8. Nursing will complete the Resident Transfer Form and send the following documents with the resident at the time of the transfer. Resident Transfer Form...." 3.1-12(a)(3)		Step 3 Licensed Nurses were re-educated on the Policy "Transfer and Discharge Requirements" with an emphasis on completing the Resident Transfer form and sending it with the resident to the hospital. Step 4 The Director of Nursing or designee will Quality Assurance Review to ensure the Resident Transfer Form is sent with the resident to the hospital weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director and the Quality Assurance Performance Improvement Committee monthly.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	155503	A. BUILDING 00 B. WING	11/04/2019

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure a Notice of Transfer or Discharge was provided to a resident with a hospitalization for 1 of 2 residents reviewed for hospitalizations (Resident 34). Findings include: Resident 34's record was reviewed on 10/31/19 at 10:28 a.m. An annual Minimum Data Set (MDS) assessment, dated 9/19/19, indicated the resident was cognitively intact. Diagnoses on the resident's profile included, but were not limited to, chronic diastolic congestive heart failure (part of the heart becomes thick and stiff, making the heart unable to pump enough blood to the body). A nursing note, dated 7/9/19, indicated the resident complained of chest pain and shortness of breath. The physician was notified, and ordered the resident sent to the emergency room (ER). The	F 0623	It is the Policy of Exceptional Living Center of Brazil to ensure a Notice of Transfer or Discharge is provided to a resident with a hospitalization. Step 1 Resident 34 has returned to the facility and remains stable at this time. Step 2 The facility will ensure that the Notice of Transfer or Discharge form is provided to the resident and/or the Responsible Party with a hospitalization. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review residents who were sent to the hospital to ensure the Notice of Transfer or Discharge form was provided to the resident and/or the Responsible Party; if this is not documented; one will be mailed to	12/04/2019

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	note lacked documentation an Notice of Transfer or Discharge was provided to the resident or resident representative. A nursing note, dated 7/15/19, indicated the resident returned to the facility. The note lacked documentation a Notice of Transfer or Discharge had been provided to the resident or resident representative. A nursing note, dated 9/7/19, indicated the Certified Nursing Assistant (CNA) reported to the nurse the resident had increased shortness of breath. The nurse practitioner (NP) was notified and ordered the resident sent to the ER. The note lacked documentation a Notice of Transfer or Discharge was provided to the resident or resident representative. Census information indicated the resident returned to the facility on 9/11/19. During an interview, on 11/1/19 at 10:22 a.m., the Director of Nursing (DON) indicated she was unable to find any documentation the Notice of Transfer or Discharge was provided to the resident or resident representative at the time of the hospital transfers in July or September, 2019. The notice should have been provided. On 11/1/19 at 11:44 a.m., the DON provided a blank copy of a document titled, "NOTICE OF TRANSFER OR DISCHARGE," and indicated it should have been provided to the resident or resident representative at the time of the hospital transfers. The notice included resident information, reason for transfer or discharge, bed hold policy contact information, appeal rights, and the state long term care ombudsman contact information.		the resident and/or Responsible Party. Step 3 Licensed Nurses were re-educated to ensure a Notice of Transfer or Discharge from is provided to the resident and/or the Responsible Party with a hospitalization and to document that the form was provided in the Medical Record. Step 4 The Director of Nursing or designee will Quality Assurance Review to ensure a Notice of Transfer or Discharge form was provided to the resident and/or the Responsible Party when a resident is sent to the hospital weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director and the Quality Assurance Performance Improvement Committee monthly.	

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	3.1-12(a)(8)(D) 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which			

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	specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure a bed hold policy was provided to a resident with a hospitalization for 1 of 2 residents reviewed for hospitalizations (Resident 34). Findings include: Resident 34's record was reviewed on 10/31/19 at 10:28 a.m. An annual Minimum Data Set (MDS) assessment, dated 9/19/19, indicated the resident was cognitively intact. Diagnoses on the resident's profile included, but were not limited to, chronic diastolic congestive heart failure (part of the heart becomes thick and stiff, making the heart unable to pump enough blood to the body). A nursing note, dated 7/9/19, indicated the resident complained of chest pain and shortness of breath. The physician was notified, and ordered the resident sent to the emergency room (ER). The note lacked documentation a bed hold policy was provided to the resident or resident representative. A nursing note, dated 7/15/19, indicated the resident returned to the facility. The note lacked documentation a bed hold policy had been provided to the resident or resident representative. A nursing note, dated 9/7/19, indicated the Certified Nursing Assistant (CNA) reported to the nurse the resident had increased shortness of breath. The nurse practitioner (NP) was notified and ordered the resident sent to the ER. The note	F 0625	It is the Policy of Exceptional Living Center of Brazil to ensure a Bed Hold Policy is provided to a resident with a hospitalization. Step 1 Resident 34 has returned to the facility and remains stable at this time. Step 2 The facility will ensure that the Bed Hold Policy is provided to the resident and/or the Responsible Party with a hospitalization. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review residents who were sent to the hospital to ensure a Bed Hold Policy was provided to the resident and/or the Responsible Party; if this is not documented; one will be mailed to the resident and/or Responsible Party. Step 3 Licensed Nurses were re-educated to ensure a Bed Hold Policy is provided to the resident and/or the Responsible Party with a hospitalization and to document that the form was provided in the Medical Record. Step 4 The Director of Nursing or designee will Quality Assurance Review to ensure a Bed Hold Policy was provided to the resident and/or the Responsible Party when a resident is sent to	12/04/2019

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	lacked documentation a bed hold policy was provided to the resident or resident representative. Census information indicated the resident returned to the facility on 9/11/19. During an interview, on 11/1/19 at 10:22 a.m., the Director of Nursing (DON) indicated she was unable to find any documentation the bed hold policy was provided to the resident or resident representative at the time of the hospital transfers in July or September, 2019. The policy should have been provided. On 11/1/19 at 11:44 a.m., the DON provided a document titled, "BED HOLD AND RETURN TO CENTER POLICY," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: To ensure that residents are made aware of a facility's bed-hold policy, State bed hold duration and payment and their right to return to the facility, if appropriate. Bed Hold Notice: ...2. A copy of the facility Bed Hold Policy Review and Notice will be provided to the resident and/or resident representative at the time of the transfer or in cases of emergency transfer, within 24 hours. Multiple attempts to notify the resident representative will be documented in the progress notes in cases where the facility was unable to notify the representative...." 3.1-12(a)(25) 3.1-12(a)(26)		the hospital weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director and the Quality Assurance Performance Improvement Committee monthly.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			

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	Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for Hospice for 1 of 16 MDS assessments reviewed (Resident 52). Findings include: Resident 52's record was reviewed on 10/31/19 at 1:48 p.m. A significant change MDS assessment, dated 8/15/19, indicated the resident did not have a life expectancy of less than 6 months, and was not on hospice care. A hospice communication tool, dated 8/10/19, indicated the medical director/hospice team physician certified the resident had a prognosis of 6 months or less if the disease process ran its normal course. A care plan, start date 8/10/19, indicated the resident required hospice related to end of life care secondary to heart disease. During an interview, on 11/1/19 at 9:18 a.m., the MDS Coordinator indicated the she had coded the MDS assessment, dated 8/15/19, incorrectly. The resident had received hospice services and prognosis was 6 months or less if the disease ran its normal course. She had failed to code both sections correctly and mistakenly coded respite care instead of hospice care. She was going to modify her errors. On 11/1/19 at 9:40 a.m., the MDS Coordinator provided a copy of Section J of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The manual indicated,	F 0641	It is the policy of Exceptional Living Center of Brazil to ensure a Minimum Data Set assessment is accurately coded for Hospice. Step 1 Resident 52 no longer resides at the facility Step 2 The MDS coordinator completed and attestation modified at time of survey to show resident on Hospice. The MDS coordinator has completed a review current facility residents who are on Hospice Services to ensure accurate coding for Hospice is reflected on the most recent residents MDS's assessment. During Morning Clinical Meeting, the completed MDS's of Hospice residents will be reviewed for appropriate coding. Step 3 The MDS Director was re-educated to ensure when a resident is on Hospice, to ensure the Minimum Data Set is coded accurately. Step 4 The Director of Nursing or designee will perform a monthly Quality Assurance Review to ensure appropriate coding for Hospice residents. Areas of concerned will be addressed immediately. Findings will be reported to Executive Director and the Quality Assurance Performance Improvement	12/04/2019

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	"J1400: Prognosis...Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation:1) that the resident is terminally ill; or 2) the resident is receiving hospice services...." On 11/1/19 at 9:40 a.m., the MDS Coordinator provided a copy of Section O of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, and indicated it was the policy currently being used by the facility. The manual indicated, "SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS...O0100K, Hospice care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions...." 3.1-31(c)(1)		Committee monthly.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

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	promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pain was addressed during a dressing change and to provide interventions in a timely manner for a resident with a pressure ulcer (localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of usually long-term pressure) for 1 of 2 residents reviewed for pressure ulcers (Resident 252). Findings include: During a dressing change observation, on 10/30/19 at 9:38 a.m., Registered Nurse (RN) 9 and the Staff Development Coordinator (SDC) turned Resident 252 onto his side in preparation for the dressing change. RN 9 removed the old dressing to the resident's coccyx (the area at the base of the spine). RN 9 cleansed the wound. While RN 9 was wiping the wound area, the resident yelled out repeatedly, "Ouch that hurts!" RN 9 told the resident she was sorry it hurt, and the resident responded, "Sorry don't cut it, it hurts!" RN 9 went into the resident's bathroom and washed her hands. The SDC told the resident the wound doctor would be in the facility the next day, and they would talk with him about getting something to numb the area. She also asked the resident if the area hurt all the time or just during the dressing change. The resident responded the area hurt all the time. RN 9 returned to the bedside, and wiped the wound with a clean wash cloth. The resident again yelled, "Ouch that hurts!" The staff continued the procedure until asked to stop due to the resident's pain. The SDC indicated the resident had not been given anything for pain prior to the treatment. A pain medication would be administered, and the treatment completed later.	F 0686	It is the Policy of Exceptional Living Center of Brazil to ensure pain is addressed during a dressing change and to provide interventions in a timely manner for a resident with a pressure ulcer. Step 1 Resident 252 pain assessment completed by the Director of Nursing or designee. Resident 252 is now a Hospice Resident and pain medication is administered as appropriate and prior to dressing changes. Resident 252's Care Plan was reviewed and updated to ensure appropriate interventions are in place. The SDC and RN 9 were re-educated to ensure residents are properly medicated for pain before, during and after dressing changes. The SDC was re-educated to ensure appropriate interventions are placed on the resident timely and to have needed equipment shipped immediately as appropriate. Step 2 Current facility residents with skin impairments had a Pain Assessment completed and review of current pain medications. The Physician will be notified if current pain medications are ineffective.	12/04/2019

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	Resident 252's record was reviewed on 10/30/19 at 10:36 a.m. An admission Minimum Data Set (MDS) assessment, dated 8/24/19, indicated the resident had a moderate cognitive impairment and was at risk for developing pressure ulcers. Diagnoses on the resident's profile included, but were not limited to, pressure ulcer of sacral region (the area at the base of the spine) stage 3 (full-thickness skin loss potentially extending into the subcutaneous tissue layer). A Physician's Order, dated 8/21/19, indicated pressure relieving/reducing cushion in wheelchair. A Physician's Order, dated 8/21/19, indicated pressure relieving/reducing mattress on bed daily. A Physician's Order, dated 8/31/19, indicated acetaminophen (a pain medication) 325 milligrams (mg) by mouth every 4 hours as needed for mild pain. A Physician's Order, dated 8/31/19, indicated hydrocodone/acetaminophen (a pain medication) 7.5/325 mg by mouth every 6 hours for pain unspecified. A Braden Scale (an assessment to determine the resident's risk for developing pressure ulcers) for pressure ulcer prediction, dated 9/30/19, indicated a score of 13, moderate risk for pressure ulcer development. A Wound Management Report, dated 10/24/19, indicated the resident had a stage 3 pressure ulcer to the coccyx, identified on 10/24/19. The area measured 3 centimeters (cm) in length, 1.5 cm in width, and 0.1 cm in depth.		Current facility residents with skin impairments Care Plans were reviewed and updated to ensure appropriate interventions are in place. Residents will be properly medicated for pain before, during and after the dressing changes. Step 3 Licensed Nurses were re-educated to ensure residents are properly medicated for pain before, during and after dressing changes. Step 4 The Director of Nursing or designee will Quality Assurance Review via observation of dressing changes to ensure residents are properly medicated for pain before, during and after dressing changes weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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A supply order, dated 10/24/19, indicated an Apex dual-gel foam cushion (a wheelchair cushion to redistribute pressure) was ordered for the resident.

An event, dated 10/25/19, indicated the resident acquired a stage 3 pressure ulcer to the coccyx. Preventative measures included, but were not limited to, pressure reducing device for chair and bed. A new cushion for the resident's wheelchair would be ordered.

A Physician's Order, dated 10/25/19, indicated cleanse coccyx with normal saline, pat dry, apply skin prep (provides a protective film to the skin) to peri wound (area surrounding wound), calcium alginate with silver (a highly absorbent dressing that promotes healing) to wound bed, cover with opti-foam (a foam dressing with an adhesive border), change daily and as needed.

A Physician's Order, dated 10/28/19, indicated low air loss mattress (a mattress to prevent and treat pressure wounds) to the bed.

A pain assessment on the Treatment Administration Record (TAR), dated 10/30/19, indicated the resident was in pain on day shift.

A Medication Administration Record (MAR), dated October 2019, lacked documentation acetaminophen or hydrocodone/acetaminophen were administered on 10/30/19.

A Wound Management Report, dated 10/31/19, indicated the stage 3 pressure ulcer to the coccyx measured 1 cm in length, 0.4 cm in width, and 0.1 cm in depth.

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A care plan, goal target dated 2/1/20, indicated the resident had chronic pain related to skin breakdown. Interventions included, but were not limited to, medications as ordered.

A care plan, goal target dated 2/1/20, indicated the resident was at risk for impaired skin integrity causing a stage 3 pressure ulcer to the coccyx. Interventions included, but were not limited to, low air loss mattress, dated 10/28/19, and wheelchair cushion when indicated, dated 10/24/19.

During an interview, on 10/30/19 at 10:50 a.m., the Staff Development Coordinator (SDC) indicated the resident had a stage 3 pressure ulcer. The area was found on 10/24/19. The low air loss mattress was not placed until 10/28/19. The resident was on the facility's standard pressure redistribution mattress from 10/24/19 to 10/28/19 because they had to retrieve the low air loss mattress from storage.

During an interview, on 10/30/19 at 1:16 p.m., the SDC indicated the resident's dressing change had been completed. She thought the resident was administered a medication for pain.

On 10/30/19 at 1:45 p.m., the SDC provided an Owner's Manual titled, "Panacea FOAM MATTRESS," and indicated it was the pressure redistributing mattress currently being used by the facility. The resident had the Panacea foam mattress until a low air loss mattress was placed on 10/28/19. The owner's manual indicated, "...WARNING-This mattress is not intended for stage III or IV pressure ulcers...." At the same time the SDC provided a document titled, "The EquaGel Straight Comfort Cushion," and indicated it was the cushion the resident currently had in

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place.

During an interview, on 10/30/19 at 2:07 p.m., the SDC indicated the wound doctor requested the gel foam wheelchair cushion during wound rounds on 10/24/19. It was ordered, but had not come in yet. She requested it on overnight delivery today.

During an interview, on 10/30/19 at 2:54 p.m., RN 9 indicated she had not administered any pain medication to the resident prior to the dressing change completion. There was no hydrocodone in stock, and approval was needed to remove it from the emergency drug kit (EDK). She was unsure why acetaminophen had not been administered. The resident told her to put the dressing on so he could get up for lunch. The resident yelled out when he was turned for the dressing change, but not when the dressing was applied.

During an interview, on 10/30/19 at 3:07 p.m., the resident indicated it was painful when they put the dressing on earlier. Indicated the area hurts, "all the time." The resident was unable to verbalize a number on the pain scale. Pain medication did not help the pain.

During an interview on 10/31/19 at 9:00 a.m., the wound doctor indicated the resident had not complained of pain last week, during his assessment.

During an interview, on 10/31/19 at 10:12 a.m., the SDC indicated she was unaware the Panacea foam mattress was not appropriate for residents with stage 3 pressure ulcers.

On 10/31/19 at 2:10 p.m., the SDC provided a document titled, "Skin and Wound Care

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	Management Program," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to: ...Promote the healing of existing pressure ulcers/injuries...Prevent development of additional pressure ulcer/injury...Implementation: The Interdisciplinary Team ensures that planned interventions and treatments are carried out as written in the Care Plan...." On 10/31/19 at 2:10 p.m., the SDC provided a document titled, "PAIN MANAGEMENT PROGRAM," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: Promote recognition and intervention to manage pain at the individuals goal or tolerance level to promote the highest quality of life practicable. Procedure: ...3. Goals of Pain Management: The goal of this program is to manage the resident's pain to optimize their quality of life. The goal of the interdisciplinary team is to promptly identify pain and develop an effective individualized Pain Management Plan (PMP). 4. The 5th Vital Sign...Healthcare clinicians must listen carefully to residents when they report pain...." 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience			

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	reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, interview, and record review, the facility failed to ensure a resident admitted with limited range of motion (ROM) received services to ensure the resident did not have a further decline in ROM (Resident 17). Findings include: On 10/28/19 at 10:48 a.m., Resident 17 was observed lying in bed. The resident's hands appeared hyperextended and the fingers on both hands appeared crooked. The resident was unable to make a fist with either hand, but used her thumb to grasp objects. Resident 17 indicated she was unable to make a fist with either hand. On 10/30/19 at 2:30 p.m., the Director of Nursing (DON) indicated, she could not locate documentation in the resident's medical record that the resident had impairments in her hands. The resident had been seen by therapy in the past for her hand impairments, but therapy was on a different electronic medical record system that did	F 0688	It is the Policy of Exceptional Living Center of Brazil to ensure that a resident admitted with limited range of motion (ROM) receive services to ensure the resident does not have further preventable decline in ROM Step 1 Resident 17 had an Occupational Therapy Evaluation and was referred to the Restorative Program. Step 2 The Director of Rehab and the Director of Nursing or SDC reviewed current facility residents for decline in Range of Motion; those with a decline received an Occupational Therapy Evaluation and either placed on therapy or was referred to the Restorative Program. The Licensed Nurses and Certified Nursing Assistants will complete a	12/04/2019

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	not transfer documentation into the resident's facility medical record. On 10/31/19 at 11:11 a.m., the Minimum Data Set (MDS) Coordinator indicated, for the last MDS assessment, dated 8/8/19, the resident was able to make a fist with both hands and her fingers were not all bent and crooked. Staff should have informed nursing or therapy about the resident's decline in ROM in her hands. This effects the resident's quality of life. There was no documentation in the resident's medical record, which indicated the resident had any impairments in her hands. The resident has had a decline and a significant change in status assessment needed to be completed with the impairments in bilateral hands noted in the assessment. On 10/31/19 at 11:18 a.m., MDS indicated, occupational therapy (OT) had seen Resident 17 in the past for her hand impairments and rheumatoid arthritis (RA). Nursing should have informed therapy Resident 17's hand impairments and RA were worse and OT would have worked with the resident to prevent a further decline. Staff should have documented in progress notes, initiated a care plan for the hand impairments, and notified therapy via a referral form about the resident's change in condition. On 10/31/19 at 1:24 p.m., Resident 17's family indicated, Resident 17's hands and fingers were slightly bent and crooked, when the resident admitted to the facility in 2009. The hand impairments were bad, but have been worse lately. The resident had therapy several times here at this facility, in the past years. The last couple of years, Resident 17's hand impairments had gotten worse On 10/31/19 at 2:00 p.m., OT indicated, staff		"Therapy Referral Form" when a resident exhibits a decline in Range of Motion for a referral to Therapy or Restorative The Clinical IDT will review facility residents on a Quarterly basis for decline in Range of Motion and will refer to Rehab or Restorative as appropriate. Step 3 Licensed Nurses and Certified Nursing Assistants were educated to ensure the Charge Nurse and/ or a Nurse Manager is notified and to complete the form titled "Therapy Referral Form" and put the completed form under the Director of Nurses' door. Step 4 The Director of Nursing or designee will perform Quality Assurance Review via rounds and interviews with staff to ensure residents who exhibit a decline in Range of Motion are referred to Therapy and/or Restorative. The rounds will be conducted weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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should have completed a referral form for therapy, if the resident's hand impairments were worse. Therapy completed quarterly screens and the resident had not had any changes, since the last screen completed on 8/8/19. Resident 17 had joint deformities in both hands from the RA, called swan neck deformity common with degenerative joint disease (DJD) and RA, which caused the limitation in extremities. Therapy could possibly have done splinting of both hands. Therapy gave Resident 17 built-up eating utensils in 2016, because of the deformities in her hands. The resident was to be evaluated by OT he next day. The resident did not have contractures, but joint deformities in both hands.

On 11/01/19 at 8:59 a.m., DON indicated, nursing staff would have charted in the progress notes and made a referral to therapy, if the resident had had a change in condition, pertaining to her hands. DON indicated she had started working at the facility in February, 2019 and the resident's hands were hyperextended and the fingers were crooked, when she began working at the facility. Resident 17 did not have a care plan pertaining to her RA and impairments in her bilateral hands, which should have included built-up eating utensils.

Resident 17's record was reviewed on 10/30/19 at 11:38 a.m. Diagnoses included, but were not limited to, rheumatoid arthritis without rheumatoid factor, unspecified hand (RA) and dementia (a group of thinking and social symptoms that interferes with daily functioning).

A quarterly MDS assessment, dated 8/8/19, indicated, the resident had severe cognitive impairment, required supervision of one person for eating, and had a no upper extremity nor lower

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	extremity impairments in functional limitations in range of motion. An October, 2019 physician order report, dated 10/1/19 to 11/1/19, indicated the resident was on a pureed diet in a divided plate and nectar thick liquids in a 2 handled cup. The record lacked documentation for built-up eating utensils nor a care plan for the resident's joint deformities in her hands. On 11/1/19 at 9:00 a.m., the DON provided and identified as a current facility policy, dated January 2018, titled "Referral to Rehab Policy," which indicated, " ...Rehabilitation services are provided only upon a written referral to rehab from a patient's physician or member of the nursing staff and only as directed by physician's order ...." 3.1-42(a)(2)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure fortified food interventions were implemented as recommended for a resident who experienced severe weight loss of 18 % within a 6 month period for 1 of 1 resident reviewed for nutrition (Resident 39). Findings include: Resident 39's record was reviewed on 11/1/19 at 9:40 a.m. Diagnosis on the resident's profile included, but were not limited to, unspecified dementia without behavioral disturbance. A quarterly Minimum Data Set (MDS) assessment, dated 9/30/19, indicated the resident had severe cognitive impairment, required extensive assistance of one person for eating, and had a significant weight loss, but was not on a physician prescribed weight loss regimen. A nutritional status care plan, initiated on 6/18/18 and last revised on 10/25/19, indicated the resident was at risk for potential alteration of nutrition and/or weight status with significant weight loss. Interventions included, but were not limited to, provide diet as ordered, assist resident as needed for eating/drinking, provide supplements and medications as ordered, honor preferences and offer alternate items if consumption was poor, obtain and evaluate weights as ordered/per policy, and notify physician, dietitian, and family of any significant	F 0692	Exceptional Living Center of Brazil respectfully requests a face-to-face Informal Dispute Resolution (IDR). It is the Policy of Exceptional Living Center of Brazil to ensure fortified food interventions are implemented as recommended for a resident who experiences weight loss. Step 1 Resident 39 was assessed by the Registered Dietitian to ensure appropriate interventions are in place to assist in preventing weight loss. The facility contends there was continued effort to prevent weight loss as evidence by multiple interventions implemented including but not limited to Dietary Supplements, Registered Dietician assessments and recommendations, Speech Therapy evaluation and treatment, food consistency modifications, adaptive equipment, one to one assist, etc. Dietary Manger (DM) was educated to follow up with family as appropriate. Step 2 Current facility residents who trigger for significant weight loss were assessed by the Registered	12/04/2019

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	changes. A review of the resident's electronic medical record for weights and body mass index (BMI) indicated: 4/16/19: weight was 127.2 pounds (lbs.) and BMI was 22.53 (normal). 7/22/19: weight was 118.4 lbs., BMI was 20.97 (normal), and had 6.92% weight loss 9/1/19: weight was 107.2 lbs., BMI was 18.99 (normal), and had a 15.72% weight loss 9/25/19: weight was 108 lbs., BMI was 19.09 (normal) 10/1/19: weight was 106.2 lbs., BMI was 18.81 (normal) 10/8/19: weight was 107.6 lbs., BMI was 19.06 (normal) 10/15/19: weight was 104.2 lbs., BMI was 18.46 (underweight) 10/25/19: weight was 104.2 lbs., BMI was 18.46 (underweight), and had a 18.08% weight loss A Dietary Manager's (DM) progress note, dated 7/25/19 at 10:35 a.m., indicated the DM had returned a phone call and left a voice mail message to Resident 39's family. Reason for call was returning family's call regarding concerns of increased weight loss with the resident. Dietician and writer discussed the next step would be to add fortified milk, fortified cereal, and fortified mashed potatoes to resident's meal plan. The writer was to follow up with family to ensure they were made aware of dietary changes to assist with resident's weight loss. A DM's progress note, dated 7/26/19 at 12:42 p.m., indicated the DM had spoken with family, and informed them of the dietician and writer's decision to start resident on fortified foods to address weight loss. Family was pleased with this		Dietician to ensure appropriate interventions are in place to assist in preventing weight loss. The Director of Nursing or designee will meet with the Registered Dietician after each visit to review residents that have triggered for significant weight loss. During this meeting the recommended interventions to assist in preventing further weight loss will be discussed. The Director of Nursing or designee will then discuss those recommendations with the Primary Care Physician and will obtain further orders as appropriate. Care Plans will be reviewed and updated to reflect new interventions as appropriate. The Director of Nursing or designee will then notify the Responsible Party of the new interventions. Step 3 Licensed Nurses were re-educated that when a resident experiences a significant weight loss to complete a "Significant Weight Loss Event" for follow-up by the Director of Nursing or designee. Step 4 The Executive Director or designee will perform Quality Assurance Review to ensure the Registered Dietician has assessed residents who trigger for significant weight loss, recommendations have been discussed with the Primary Care	

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	decision. Writer to check in with family in a couple weeks to report progress with intakes and weight of resident. A Registered Dietitian (RD) progress note, dated 10/17/19, indicated mighty shake had been added to meal times, but resident continued with inconsistent intake of food on puree diet. Weight continued to be monitored weekly. No additional recommendations at this time. A RD nutrition observation note, dated 10/25/19 at 12:55 p.m., indicated the resident had experienced significant weight loss in 90 days and 180 days, with a BMI of 18.46%, the underweight range A RD progress note, dated 11/1/19, indicated the resident was receiving a puree diet with a divided plate, fortified milk, magic cup, and mighty shake at all meals. Remeron (appetite stimulant) 15 milligrams (mg) was added by the physician on October 30. The DM to follow up with resident's family regarding clarification of current interventions. An October, 2019 physician order report, dated 10/1/19 to 11/1/19, indicated the resident was on a pureed diet, received magic cups and mighty shakes with meals, and as of 10/30/19 Remeron was ordered by the physician daily for weight loss. The record lacked documentation any additional nutritional supplements or fortified foods were ordered for the resident. During an interview, on 11/1/19 at 10:57 a.m., the RD indicated the resident's weight had been stable since September 1, 2019. In June, the resident was evaluated by therapy and placed on a puree diet and given magic cups ice cream with		Physician, interventions have been ordered and Care Planned and the Responsible Party has been notified. The Review will occur weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	

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meals. The resident had the weight loss due to poor intake and dementia. For the most recent weight loss, mighty shakes with meals was included. The doctor added the medication, Remeron, an appetite stimulant, on 10/30/19. The resident received fortified milk with each meal, but the resident did not receive any additional fortified foods. The fortified foods order should have been documented and ordered, on 7/26/19, when the DM had talked to the family. The fortified foods order just got missed. The RD indicated, she was unsure of the facility's policy and procedure for significant weight loss, since she was a contracted employee. The Director of Nursing (DON) should have a facility policy and procedure for weight loss.

During a telephone interview, on 11/1/19 at 1:56 p.m., Resident 39's family indicated they had not spoken to staff at the facility about Resident 39's weight loss, since the care plan meeting on 10/21/19. The family was concerned about her weight loss and the pureed diet. She was wasting away. At the care plan meeting, the family had requested Resident 39 be reevaluated by therapy to be put back on her finger foods diet.

On 11/1/19 at 2:30 p.m., the DON provided and identified as a current facility policy and procedure, dated 1/15/12, titled, "Interventions For Unintended Weight Loss," which indicated, "...The facility has a weight tracking program to identify any individuals with unintended weight loss to assess problems and appropriately intervene...."

On 11/4/19 at 3:34 p.m., the DON provided a facility document, titled "Performance Improvement Plan," dated 9/24/19, which indicated "...Identified Issue(s): Weights obtained

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	timely and follow-up completed with weight change...Resident who had a triggered for a significant weight change had an Event completed with the Physician and Responsible notification completed. Each of the identified residents were reviewed by the Registered Dietician for appropriate interventions. Care plans were reviewed and updated as appropriate...The Registered Dietician will review residents with significant weight changes. The Registered Dietician will complete the Observation in the Medical Record and make recommendation as appropriate and will provide the Director of Nursing a list of said recommendations...." 3.1-46(a)(1)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review, the facility failed to provide adequate person-centered Dementia care and services and monitor the effectiveness of interventions, to prevent the potential for behaviors for 1 of 3 residents reviewed for Dementia care (Resident 8). Findings include: During an interview, on 10/30/19 at 10:37 a.m., Licensed Practical Nurse (LPN) 5 indicated when the resident had behaviors they would redirect the resident with activities, provide a snack or coffee, or walk with the resident providing 1:1. She was	F 0744	It is the Policy of Exceptional Living Center of Brazil to provide adequate person-centered Dementia care and services and monitor the effectiveness of interventions, to prevent the potential of behaviors. Step 1 Resident 8 was assessed by the Social Services Director and the Activities Director to ensure his specific likes and past activities the resident enjoyed along with interventions for activities. Resident 8's Care Plans were	12/04/2019

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	unsure of any other resident-specific interventions and when asked how she would know of more resident-specific interventions she indicated she would ask the family when they came in if they needed to. She did not identify they could refer to the resident's care plan for interventions to use. During an interview, on 10/30/19 at 2:54 p.m., Certified Nursing Assistant (CNA) 4 indicated the resident had behaviors and did not always respond well to redirection. She was unsure what guidelines and protocols the facility used for dementia care but had received annual dementia care training. If the resident had behaviors she would try to redirect the resident by offering snacks, an activity, sometimes television or a variety of music. She was unsure what the resident-specific care plan included. Resident 8's record was reviewed on 10/30/19 at 9:07 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance (include symptoms such as depression, anxiety psychosis, agitation, aggression, and sleep disturbances), brief psychotic disorder (uncommon psychiatric condition characterized by sudden and temporary periods of psychotic behavior), unspecified psychosis (loss of contact with reality), generalized anxiety disorder (excessive, uncontrollable and often irrational worry), and other specified depressive episodes (depressed mood or loss interest in activities). A review of the residents behavior monitoring, dated May 2019 through August 2019, indicated the resident had behaviors of pacing and anxiety on the following dates:		reviewed and updated as appropriate along with initiation of monitoring the effectiveness of the interventions to prevent the potential for behaviors. Step 2 Current facility with a diagnosis of Dementia were assessed by the Social Services Director and the Activities Director to ensure his/her specific likes and past activities the resident enjoyed along with interventions for activities. Care Plans were reviewed and updated as appropriate along with initiation of monitoring the effectiveness of the interventions to prevent the potential for behaviors. The Clinical Interdisciplinary Team will review upon admission and quarterly, residents with a diagnosis of Dementia to to ensure his/her specific likes and past activities the resident enjoyed along with interventions for activities. Care Plans will be reviewed and updated as appropriate along with initiation of monitoring the effectiveness of the interventions to prevent the potential for behaviors. Step 3 The Clinical Interdisciplinary Team, Licensed Nurses, Certified Nursing Assistants and Activity Assistants were educated to ensure activities are resident specific for residents with Dementia. To obtain the resident	

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	a. On 5/1/19, night shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. b. On 5/3/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. c. On 5/7/19, night shift; frequency, 9 times. Lacked documentation of interventions used and effectiveness of interventions. d. On 5/9/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. e. On 5/11/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. f. On 5/17/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. g. On 5/23/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. h. On 5/24/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. i. On 5/25/19, day shift; frequency, 4 times. Lacked documentation of interventions used and effectiveness of interventions. j. On 5/26/19, day shift; frequency, 4 times. Lacked documentation of interventions used and effectiveness of interventions.		specific activities/interventions, review the Care Plan and/or the Kiosk or by asking the Licensed Nurse. Staff need to ensure monitoring for effectiveness to prevent the potential for behaviors is completed. Step 4 The Director of Nursing or designee will perform Quality Assurance Review on residents with a diagnosis of Dementia to ensure resident specific activities are Care Planned and the staff are monitoring for effectiveness 3-5 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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	k. On 5/30/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. l. On 5/30/19, night shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. m. On 6/6/19, day shift; frequency, 3 times. Lacked documentation of interventions used and effectiveness of interventions. n. On 6/6/19, night shift; frequency, 3 times. Lacked documentation of interventions used and effectiveness of interventions. o. On 6/7/19, day shift; frequency, 1 time. Lacked documentation of interventions used and effectiveness of interventions. p. On 6/8/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. q. On 7/10/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. r. On 7/12/19, night shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. s. On 7/19/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. t. On 7/21/19, day shift; frequency, 4 times. Lacked documentation of interventions used and effectiveness of interventions.			

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	u. On 7/25/19, day shift; frequency, 3 times. Lacked documentation of interventions used and effectiveness of interventions. v. On 7/26/19, day shift; frequency, 5 times. Lacked documentation of interventions used and effectiveness of interventions. w. On 7/26/19, night shift; frequency, 1 time. Lacked documentation of interventions used and effectiveness of interventions. x. On 7/27/19, day shift; frequency, greater than 10 times. Lacked documentation of interventions used and effectiveness of interventions. y. On 8/1/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. z. On 8/2/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions. aa.. On 8/2/19, night shift; frequency, intermittent. Lacked documentation of interventions used and effectiveness of interventions. bb. On 8/9/19, night shift; frequency, greater than 5 times. Lacked documentation of interventions used and effectiveness of interventions. cc. On 8/15/19, night shift; frequency, greater than 10 times. Lacked documentation of interventions used and effectiveness of interventions. dd. On 8/16/19, day shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions.			

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ee. On 8/16/19, night shift; frequency, 3 times. Lacked documentation of interventions used and effectiveness of interventions.

ff. On 8/21/19, day shift; frequency, 4 times. Lacked documentation of interventions used and effectiveness of interventions.

gg. On 8/24/19, night shift; frequency, 2 times. Lacked documentation of interventions used and effectiveness of interventions.

A care plan, goal target date of 1/21/20, indicated the resident preferred activities that identified with prior lifestyle. He raised goats for many years. He enjoyed joking with staff, playing games, current events and pets. Interventions included, but were not limited to, resident enjoyed keeping up with the news and playing games, listening to music especially classic country, religious services, reading books, newspapers, and magazines.

A care plan, goal target date of 1/21/20, indicated the resident required placement on a secured unit due to wandering and elopement risk related to a diagnosis of dementia. Interventions included, but were not limited to, observe for increased behaviors, anxiety, and depressive symptoms.

A care plan, goal target date of 1/21/20, indicated the resident had a memory/recall problem related to dementia. Interventions included, but were not limited to, review photographs, memory books, keepsakes with resident.

A care plan, goal target date of 1/21/20, indicated the resident wandered aimlessly.

A care plan, goal target date of 1/21/20, indicated the resident required the use of anti-anxiety

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medications due to a diagnosis of anxiety disorder and was at risk for adverse reactions. Interventions included, but were not limited to, administer medication as ordered and observe of changes in mood/behavior.

On 11/1/19 at 8:55 a.m., the Director of Nursing (DON) provided a policy, titled, "Evaluation and Assessment of the Resident with Dementia," and indicated it was the policy currently being used by the facility. The policy indicated, "Residents with any type of dementia are assessed in the same way as all other residents of the facility...In addition, ensure the assessment and evaluation process results in a care plan that promotes individual dignity, optimizes health and well-being and maximizes function. Implement the care plan in a resident-focused and flexible manner...Use the assessment and evaluation process and tools to create an appropriate care plan and help staff understand; Who a resident is; what their strengths and limitations are; what they need; how best to respond to their changing needs; and prior routines and schedules...."

On 11/1/19 at 10:10 a.m., the Director of Nursing (DON) provided a policy, dated 6/25/17, and titled, "Behavior Assessment and Management," and indicated it was the policy currently being used by the facility. The policy indicated, "It is important to understand causes of behavior problems in our residents. Examples of behavior problems can include a depressed resident withdrawing from other people, an agitated resident shouting repeatedly...or a confused resident wandering from his or her unit. Behavioral health encompasses a residents whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance abuse...Alzheimer's

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	disease and related dementia's as well as mental illness diagnosis can cause a person to act in different and unpredictable ways. Some become anxious or aggressive. Others repeat certain questions or gestures. Many misinterpret what they hear. These reactions can lead to misunderstanding, frustration and tension, particularly between the person with disease process and caregiver. It is important to understand that usually the person is not acting that way on purpose...1. Examine the behavior...2. Explore potential solutions...3. Try different responses: Did your new response help? Do you need to explore other potential causes and solutions? If so, what can you do differently...Care planning of resident behaviors: Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and lives of those with whom the resident interacts. Once behaviors have been assessed, the next step is to develop a resident-specific care plan based directly on the conclusion/underlying cause...The focus of the care plan should be to address the underlying cause or causes, reversing the daily display of troubling behaviors, and preventing any harm from occurring...." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or			

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	§483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to ensure a physician's documented rationale for the declination of a pharmacy recommendation (Resident 32), failed to address a pharmacy recommendation related to a lab in a timely manner and to document vital signs per a pharmacy recommendation (Resident 26), and failed to ensure blood pressures were monitored with the administration of blood pressure medications and to ensure the availability of medications to be administered (Resident 8), for 3 of 5 residents reviewed for unnecessary medications. Findings include: 1. Resident 32's record was reviewed on 10/30/19 at 9:42 a.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (ESRD-chronic irreversible renal failure), and chronic atrial fibrillation (Afib-a disease of the heart characterized by irregular and often faster heartbeat).	F 0757	It is the Policy of Exceptional Living Center of Brazil to ensure a physician's documented rational for the declination of a pharmacy recommendation, pharmacy recommendations related to labs are completed timely and to document vital signs per the pharmacy recommendation. It is also the Policy of Exceptional Living Center of Brazil to ensure Blood Pressures are monitored with the administration of blood pressure mediations per the physician's order and ensure the availability of medications to be administered. Step 1 Resident 32's Pharmacy recommendation dated 6/7/19 has been reviewed by the New Primary Care Physician. The Eliquis was not changed per the specialists recommendations and the	12/04/2019

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	An admission Minimum Data Set (MDS) assessment, dated 4/5/19, indicated the resident's medications included, but were not limited to anticoagulants (an agent that is used to prevent the formation of blood clots). A care plan, dated 4/09/19, indicated the resident had a diagnosis of Afib and was at risk for chest pain, weakness, fainting, nausea and irregular heartbeat. Interventions included, but were not limited to, adminsiter medications as ordered. A pharmacy consultation report, dated 6/7/19, indicated the resident had received Eliquis (medication used to prevent serious blood clots from forming due to a certain irregular heartbeat or after surgery) 2.5 milligrams (mg) twice daily. The recommended dose was 5 mg twice daily, in residents with Afib and ESRD maintained on hemodialysis. The document recommended to consider increasing the dose to 5 mg twice daily. The physician declined the recommendation. No documented rationale to support the declination was observed. A pharmacy consultation report, dated 6/7/19, indicated the resident had received loratadine (an antihistamine that treats symptoms such as itching, runny nose, watery eyes, and sneezing from "hay fever" and other allergies) 10 mg daily and received dialysis. The recommended dose was 10 mg every-other-day, or another option would be 5 mg daily. The physician declined the recommendation. No documented rationale to support the declination was observed. 2. Resident 26's record was reviewed on 10/29/19 at 1:59 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance (general term describing problems		Loratadine has been discontinued. Resident 26 Pharmacy recommendation dated 9/7/19 was reviewed by the New Primary Care Physician/Medical Director and per his recommendations Resident 26's vital signs will be obtained monthly; to be completed at the time of the monthly weight. Resident 8 was assessed by the Director of Nursing or designee and suffered no ill affects related to potentially not receiving his prescribed medication. Per the Primary Care Physician/Medical Director Resident 8's Vital Signs will be obtained monthly; to be completed at the time of the monthly weight. Step 2 The Pharmacist Consultant reviewed current facility residents on 11/12/2019; the Pharmacy Recommendations have been reviewed by the Primary Care Physicians with follow through as appropriate. The Director of Nursing or designee will receive the Pharmacy Recommendation on the day of the Pharmacists visit; she will then review them with the Primary Care Physician or the Medical Director if the Primary Car Physician not available and will ensure appropriate follow through. The Director of Nursing will complete the Pharmacy Recommendations within 7-10	

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	with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone), and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly caused poor blood flow). A quarterly Minimum Data Set (MDS) assessment, dated 9/6/19, indicated the resident was severely cognitively impaired, received an anticoagulant (blood thinner) 7 days of the assessment look back period. A physician's order, dated 6/13/17, indicated levothyroxine (thyroid medicine that replaced a hormone normally produced by the thyroid gland to regulate the body's energy and metabolism) 75 micrograms (mcg) by mouth daily for hypothyroidism. A physician's order, dated 8/25/18, indicated Xarelto (an anticoagulant) 15 milligrams (mg) by mouth daily for paroxysmal atrial fibrillation. A pharmacy recommendation, dated 7/11/19, indicated to please consider a TSH (thyroid stimulating hormone) blood test. The physician agreed and signed the recommendation on 8/20/19 and the TSH blood test had been completed on 8/22/19. A pharmacy recommendation, dated 9/7/19, indicated to please ensure VS (vital signs) were completed and documented into the Resident 26's electronic medical record. On 10/31/19 at 9:06 a.m., the Director of Nursing (DON) indicated Resident 26's vital signs had not		business days. When a medication is not available the Licensed Nurse or Qualified Medication Aide will check the Pharmacy Back-up Box (EDK); if the medication is still not available the nurse will call the pharmacy to see when the soonest the medication can be delivered. If the medication cannot be delivered within one hour after the scheduled time to administer the medication the Physician is to be notified for further orders. If the resident refuses a medication the physician is to be notified unless there is a specific order that states not to notify until so many refused doses. Step 3 The Director of Nursing and SDC were educated by the Vice President of Clinical Services that when either of them receive the Pharmacy Recommendations she is to then review them with the Primary Care Physician or the Medical Director if the Primary Car Physician not available and to ensure appropriate follow through. The Director of Nursing is to ensure these are completed within 7-10 business days. Licensed Nurses and Qualified Medication Aides were educated when a medication is not available the Licensed Nurse or Qualified Medication Aide will check the Pharmacy Back-up Box (EDK); if the medication is still not available	

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	been completed and documented. There should have been a written rationale for the declinations on the consultant reports/pharmacy recommendations. The facility did not have a written facility policy on the physician writing a declination for declined recommendations. The facility followed the State and Federal regulations. The pharmacy recommendations should have been addressed as soon as possible. The 7/11/19 recommendations that were addressed on 8/20/19, was too long of a time period. There was no policy on a time period for pharmacy recommendations to be addressed, but they should be addressed in a shorter time period and should never be addressed over a month later.3. Resident 8's record was reviewed on 10/30/19 at 9:07 a.m. The profile indicated the resident's diagnoses included, but were not limited to, hypertension (abnormally high blood pressure). A Medication Administration Record (MAR), dated July 2019, indicated Tylenol (mild pain reliever) 325 milligrams (mg), administer 650 mg twice daily for pain. The medication was not administered as ordered due to being unavailable two times on 9/19/19. The record lacked documentation the physician had been notified the medication was unavailable and had not been administered at those times. A document, titled, "Quick Reference Guide," indicated medication not available guideline- A tool to assist the nurse in handling a situation where medication is not available. Upon discovery that a medication is unavailable: Licensed nurse should take action at once and not wait until the med pass is completed. If the next available delivery causes delay or missed dose in the medication schedule, take the medication from the emergency stock supply to administer the dose. If		the nurse will call the pharmacy to see when the soonest the medication can be delivered. If the medication cannot be delivered within one hour after the scheduled time to administer the medication the Physician is to be notified for further orders. If the resident refuses a medication the physician is to be notified unless there is a specific order that states not to notify until so many refused doses. Step 4 The Vice President of Clinical Services or designee will perform Quality Assurance Review to ensure the Pharmacy Recommendations are completed as appropriate monthly for 3 months. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director monthly who will then report to the Quality Assurance Performance Improvement Committee. The Director of Nursing or designee will perform Quality Assurance Review to ensure medications are available as prescribed or the physician has been notified when a medication has not been administered 3-5 times weekly for four weeks then 1-3 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive	

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	the medication is not available in the emergency stock supply, notify the pharmacist and arrange for an emergency delivery. Action may include: emergency delivery or use of emergency back-up pharmacy. If the medication is not received the nurse should notify the Director of Nursing (DON)/designee and follow up with Physician and pharmacy. An untitled document, indicated 10 tablets of Tylenol 325 mg were available in the emergency stock supply. During an interview, on 10/31/19 at 1:38 p.m., the Director of Nursing (DON) indicated Tylenol was in the emergency drug kit (EDK) supply and was used when a medication was unavailable at the time of administration. She was unsure why the resident had missed two doses of Tylenol when it was available in the EDK. A Physician's Order, start date 4/18/19 and discontinued 7/4/19, indicated metoprolol tartrate (beta blocker used to treat high blood pressure) 25 milligrams (mg) by mouth once daily. A review of vital signs, dated 4/18/19 through 7/3/19, indicated a blood pressure (b/p) and pulse (heart rate) had been obtained at admission on 4/18/19, but lacked documentation one had been obtained from 4/19/19 through 7/3/19. A patient information leaflet for metoprolol tartrate 25 mg, indicated to have your blood pressure and pulse checked regularly while taking this medication. A progress note, dated 7/4/19 at 11:04 a.m., indicated the resident was breathing rapidly and his legs were shaking. When staff spoke to him,		Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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	he appeared pale and staring off with eyes fixed and not responding to verbal physical stimuli. He began to drool and move eyes rapidly and after a few minutes was able to answer questions. The resident's b/p was 76/50 and pulse 42. The physician was notified and new orders to hold meteprolol and monitor b/p were received. During an interview, on 10/30/19 at 2:28 p.m., the DON indicated she was unsure why there had only been one blood pressure and pulse obtained from the resident's admission date in April until July. The physician would typically order how often he wanted blood pressure and pulse readings to be obtained but had failed to do so for this resident. On 11/1/19 at 10:39 a.m., the DON provided a policy, dated 12/26/16, and titled, "Documentation in the Clinical Record," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: Guidelines for documentation...Procedure: 1. Observations, medications administered...are documented in the resident's clinical records...5. Documentation of procedures and treatments may include...e. Whether the resident refused the procedure/treatment; f. Notification of family, physician...." 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

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the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure a physician's documented rationale for the declination of a pharmacy recommendation, and a pharmacy recommendation for the dose reduction of an antianxiety medication (medication used to prevent anxiety and treat anxiety related to several anxiety disorders) was addressed in a timely manner (Resident 32), and failed to ensure antianxiety medication was administered as ordered and the physician was notified of the lack of availability of the medication and the resident refusals to allow administration (Resident 8), for 2 of 5 residents reviewed for unnecessary medications. Findings include: 1. Resident 32's record was reviewed on 10/30/19 at 9:42 a.m. The profile indicated the resident's diagnoses included, but were not limited to, other specified depressive episodes (presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning), and generalized anxiety disorder (excessive, uncontrollable and often irrational worry). An admission Minimum Data Set (MDS) assessment, dated 4/5/19, indicated the resident medications included, but were not limited to, antidepressant and antianxiety medication. A care plan, dated 3/18/19, indicated the resident required the use of antianxiety medications and was at risk for adverse reaction. Interventions	F 0758	It is the Policy of Exceptional Living Center of Brazil to ensure a physician's documents rationale for the declination of a pharmacy recommendation, to ensure Pharmacy recommendations are addressed in a timely mannerand the physician is notified when a resident does not receive a prescribed medication. Step 1 Resident 32's Pharmacy recommendation dated 6/7/19 has been reviewed by the New Primary Care Physician and completed per his orders. Resident 8 was assessed by the Director of Nursing or designee and suffered no ill affects related to potentially not receiving his prescribed medication. The Pharmacist Consultant reviewed current facility residents on 11/12/2019; the Pharmacy Recommendations have been reviewed by the Primary Care Physicians with follow through as appropriate. Step 2 Current facility residents Medication Administration records were reviewed for the last 30 days; residents who had missed or refused medications were assessed by the Director of Nursing or designee and no ill effectes were noted related to the potential of a missed prescribed	12/04/2019

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	included, but were not limited to, administer medication as ordered. A care plan, dated 4/29/19, indicated the resident presented with a diagnosis of depression. Intervention included, but were not limited to, administer medications as ordered. A pharmacy consultation report, dated 6/7/19, indicated the resident received Melatonin (used for short-term treatment of trouble sleeping due to sleep cycle disorders and time changes) 5 milligrams (mg) at bedtime, Trazodone (medication used to treat depression) 75 mg at bedtime, and alprazolam (Xanax) (antianxiety medication) 1 mg at bedtime. The document recommended to discontinue one (or more) of the agents due to duplicate therapy. The physician declined the recommendation. No documented rationale to support the declination was observed. A document titled, "Note To Attending Physician/Prescriber," dated 7/11/19, indicated the resident received a routine and PRN (as needed) Xanax order with the addition of Ativan (antianxiety medication) 3 x weekly. The document recommended to consider discontinuing one benzodiazepine (a classification of antianxiety medications) to avoid duplicate therapy. The recommendation was not addressed by the physician until 8/20/19, at which time an order to discontinue the Xanax was given. Review of the Medication Administration Record (MAR), dated July 2019, indicated an order for Xanax 0.5 mg, 1 tablet, by mouth, every 12 hours PRN for the diagnosis of generalized anxiety disorder. The start date was 6/17/19 and discontinued on 8/20/19. The MAR documented the resident had received the medication on		medication. The Director of Nursing or designee will receive the Pharmacy Recommendation on the day of the Pharmacists visit; she will then review them with the Primary Care Physician or the Medical Director if the Primary Car Physician not available and will ensure appropriate follow through. The Director of Nursing will complete the Pharmacy Recommendations within 7-10 business days. When a medication is not available the Licensed Nurse or Qualified Medication Aide will check the Pharmacy Back-up Box (EDK); if the medication is still not available the nurse will call the pharmacy to see when the soonest the medication can be delivered. If the medication can not be delivered within one hour after the scheduled time to administer the medication the Physician is to be notified for further orders. If the resident refuses a medication the physician is to be notified unless there is a specific order that states not to notify until so many refused doses. Step 3 The Director of Nursing and SDC were educated by the Vice President of Clinical Services that when either of them receive the Pharmacy Recommendations she is to then review them with the	

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	7/20/19 and 7/25/19. Review of the MAR, dated August 2019, indicated the order for Xanax was unchanged. The MAR documented the resident had received the medication on 8/4/19, 8/15/19, and 8/19/19. During an interview, on 10/30/19 at 1:56 p.m., the Director of Nursing (DON) indicated the recommendations should be addressed as soon as possible. The recommendation, dated 7/11/19, that had not been addressed until 8/20/19, had not been addressed in a timely manner. If the recommendation had been addressed timely, the resident would not have received the PRN medications between the time of the recommendation and the date the physician discontinued the medication. There was not a facility policy related to pharmacy recommendations being addressed in a timely manner. Pharmacy recommendations should have never taken over a month to be addressed.3. Resident 8's record was reviewed on 10/30/19 at 9:07 a.m. The profile indicated the resident's diagnoses included, but were not limited to, generalized anxiety disorder (excessive, uncontrollable and often irrational worry). A physician's order, start date 4/18/19, indicated buspirone (anti-anxiety) 5 milligrams (mg) three times daily by mouth for generalized anxiety disorder. A Medication Administration Record (MAR), dated May 2019, indicated buspirone 5 mg three times daily. The medication was not administered as ordered due to being unavailable 2 times on 5/26/19, 2 times on 5/27/19, and 2 times on 5/28/19. The record lacked documentation the physician had been notified the medication was unavailable		Primary Care Physician or the Medical Director if the Primary Car Physician not available and to ensure appropriate follow through. The Director of Nursing is to ensure these are completed within 7-10 business days. Licensed Nurses and Qualified Medication Aides were educated when a medication is not available the Licensed Nurse or Qualified Medication Aide will check the Pharmacy Back-up Box (EDK); if the medication is still not available the nurse will call the pharmacy to see when the soonest the medication can be delivered. If the medication can not be delivered within one hour after the scheduled time to administer the medication the Physician is to be notified for further orders. If the resident refuses a medication the physician is to be notified unless there is a specific order that states not to notify until so many refused doses. Step 4 The Vice President of Clinical Services or designee will perform Quality Assurance Review to ensure the Pharmacy Recommendations are completed as appropriate monthly for 3 months. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director monthly who will then report to the Quality Assurance	

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	and had not been administered at those times. A MAR, dated June 2019, indicated buspirone 5 mg three times daily. The medication was not administered as ordered due to resident refusals one time on 6/14/19, one time on 6/20/19, two times on 6/21/19, and one time on 6/28/19. The record lacked documentation the physician had been notified the medication had not been administered due to the resident's refusal. A MAR, dated July 2019, indicated buspirone 5 mg three times daily. The medication was not administered as ordered due to being unavailable 2 times on 7/9/19. The record lacked documentation the physician had been notified the medication was unavailable and had not been administered at those times. A MAR, dated September 2019, indicated buspirone 5 mg three times daily. The medication was not administered as ordered due to being unavailable 2 times on 9/21/19, and one time on 9/25/19. The record lacked documentation the physician had been notified the medication was unavailable and had not been administered at those times. A document, titled, "Quick Reference Guide," indicated medication not available guideline- A tool to assist the nurse in hadling a situation where medication is not available. Upon discovery that a medication is unavailable: Licensed nurse should take action at once and not wait until the med pass is completed. If the next available delivery causes delay or missed dose in the medication schedule, take the medication from the emergency stock supply to administer the dose. If the medication is not available in the emergency stock supply, notify the pharmacist and arrange		Performance Improvement Committee. The Director of Nursing or designee will perform Quality Assurance Review to ensure medications are available as prescribed or the physician has been notified when a medication has not been administered 3-5 times weekly for four weeks then 1-3 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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for an emergency delivery. Action may include: emergency delivery or use of emergency back-up pharmacy. If the medication was not received the nurse should notify the Director of Nursing (DON)/designee and follow up with Physician and pharmacy.

A care plan, goal target date of 1/21/20, indicated the resident required the use of anti-anxiety medications due to a diagnosis of anxiety disorder and was at risk for adverse reactions. Interventions included, but were not limited to, adminsiter medication as ordered.

A care plan, goal target date of 1/21/20, indicated the resident had behavioral symptoms not directed to others related to anxiety.

During an interview, on 10/31/19 at 10:19 a.m., the Director of Nursing (DON) indicated if a medication was unavailable the nurse would notify the pharmacy immediately and the physician should be notified the medication had not been administered and the reason it had not been administered. She could not find documentation the physician had been notified on those dates.

On 11/1/19 at 10:39 a.m., the DON provided a policy, dated 12/26/16, and titled, "Documentation in the Clinical Record," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: Guidelines for documentation...Procedure: 1. Observations, medications administered...are documented in the resident's clinical records...5. Documentation of procedures and treatments may include...e. Whether the resident refused the procedure/treatment; f. Notification of family, physician...."

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	3.1-48(a)(3) 3.1-48(b)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed ensure the medication administration rate was less than 5%, when the medication error rate was 6.67% for 2 of 5 residents observed for medication administration (Resident 28, and Resident 5). Findings include: During a random medication administration observation of Resident 28, on 10/31/19 at 8:43 a.m., Registered Nurse (RN) 8 was observed to administer biotin 5000 micrograms (mcg) 1 tablet by mouth. Resident 28's record was reviewed, on 10/31/19 at 10:50 a.m. A physician's order, start date 10/2/18, indicated biotin (supplement) plus keratin (biotin-keratin) over the counter (OTC); 10,000-100 mcg-milligrams (mg), administer 1 tablet by mouth daily for autonomic neuropathy (form of polyneuropathy that affects the non-voluntary, non-sensory nervous system). A Medication Administration Record (MAR), dated 10/31/19, indicated biotin plus keratin 10,000-100 mcg-mg had been administered one time from 6:00 a.m.-10:00 a.m.	F 0759	It is the Policy of Exceptional Living Center of Brazil that Medication Errors are not 5% or greater. Step 1 Resident 28 and 5 were assessed by the Director of Nursing or designee and no adverse reaction noted related to the potential of the medication error. Registered Nurse (RN) 8 no longer works at the facility. Step 2 No other residents were affected by this citation. A Nurse Manager will conduct Medication Pass observations with each Licensed Nurses annually to ensure his/her medication error rate is not 5% or greater. Step 3 The Director of Nursing or SDC conducted Medication Pass Observation with each Licensed Nurse to ensure Medication Error was not 5% or greater. Licensed Nurses with a 5% or greater error rate will receive further education and Medication Observations will	12/04/2019

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	During an interview, on 10/31/19 at 10:52 a.m., Staff Development Coordinator (SDC) indicated Resident 28's physicians order for biotin with keratin did not match the medication the resident had in the cart and the physician should have been called to address the medication available was different than what was prescribed. She was unsure why that had not already been done. During a random medication administration observation of Resident 5, on 10/31/19 at 9:26 a.m., RN 8 was observed to prepare Potassium (supplement) Chloride (Cl) 20 milliequivalent (mEq) 1 tablet, she than crushed the medication and added applesauce. At that time, this surveyor asked RN 8 if she could crush Potassium Cl and RN 8 continued to crush the medication and indicated it should not be crushed but they do because the resident could not swallow them whole. The medication was then administered. Resident 5's record was reviewed, on 10/31/19 at 11:13 a.m. The resident's diagnoses included, but were not limited, hyperkalemia (elevated level of potassium). A MAR, dated 10/31/19 at 6:00 a.m.-10:00 a.m., indicated Potassium Cl 20 mEq was administered. A resident information leaflet for Potassium Cl 20 mEq tablet indicated do not crush, chew, or suck on the tablets. Doing so can release all of the drug at once, increasing the risk of side effects. If you have trouble swallowing the tablets, you may break the tablet in half and take one half with a glass of water; then take the other half tablet with another glass of water. Another choice was to dissolve the tablet in a half glass of water.		be conducted weekly with that nurse until 3 or more consecutive observations are completed with an error rate of less than 5%. The Pharmacy will conduct Medication Pass Observations randomly throughout the next year. Step 4 The Director of Nursing or designee will perform Quality Assurance Review via Medication Pass observations 1-3 times weekly for four weeks then weekly for four weeks than monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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	During an interview, on 10/31/19 at 10:52 a.m., the SDC indicated potassium should not be crushed. On 10/31/19 at 11:11 a.m., the Corporate Consultant provided a policy, titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices...Procedure: ...3. Medications are administered in accordance with written orders of the attending physician/prescriber...4. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule...6. If it is safe to do so, medication tablets may be crushed...when a resident has difficulty swallowing...." 3.1-25(b)(9)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent			

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	covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on observation, interview, and record review, the facility failed to ensure a resident received dental services, when the resident's bottom denture plate was lost, for 1 of 1 resident reviewed for dental (Resident 17). Findings include:	F 0791	It is the Policy of Exceptional Living Center of Brazil the resident's receive dental services as appropriate. Step 1 Resident 17 has had a Dental Appointment and a new denture has been ordered.	12/04/2019

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	On 10/28/19 at 10:42 a.m., Resident 17 was observed lying in bed and indicated, her bottom denture plate had been missing for about two months. She had told staff about the missing bottom denture. Resident 17 had an upper denture plate in place, but not a bottom denture plate. On 10/30/19 at 10:40 a.m., the Social Services Director (SSD) indicated, she was the Grievance Officer and responsible for lost items but could not recall Resident 17's lost bottom denture. Normally, nursing would have notified her of a missing item. On 10/30/19 at 10:56 a.m., SSD indicated, the bottom denture plate had been missing for about a week. She had not notified the denture was missing, but had scheduled an appointment for 11/21/19 for a denture fitting. Staff should have notified me by completing a grievance/missing item form, when the denture went missing. On 10/31/19 at 1:24 p.m., Resident 17's daughter indicated, she was not aware her mother's bottom denture was missing. The resident had her dentures in place for pictures with the family on 9/11/19. Resident 17's record was reviewed on 10/30/19 at 11:38 a.m. Diagnoses included, but were not limited to, rheumatoid arthritis without rheumatoid factor, unspecified hand (RA) and dementia (a group of thinking and social symptoms that interferes with daily functioning). A quarterly MDS assessment, dated 8/8/19, indicated, the resident had severe cognitive impairment and required supervision of one person for eating.		Step 2 Current facility residents with dentures were assessed to ensure his/her dentures were not broken and/or missing. A dental appointment was scheduled for residents as appropriate. The Certified Nursing Assistant and/or the Licensed Nurse will complete a Concern form when a resident has a missing or broken denture that will be turned into the Social Services Director for follow-up. The Licensed Nurse will then initiate the Observation "ELC Dentures Lost or Damaged. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review the Observations to ensure follow-up and to schedule a Dental Appointment as appropriate. During the quarterly Care Conference Review the Clinical Interdisciplinary Team will assess the need for residents with dentures to have a Dental appointment. Step 3 Licensed Nurses and Certified Nursing Assistants were re-education that when a resident has a missing or broken denture that a concern form is to be completed . The Licensed Nurse is to initiate the Observation "ELC Dentures Lost or Damaged". The Clinical IDT will then review the Observation during the Morning Clinical Meeting to ensure	

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	155503	A. BUILDING 00 B. WING	11/04/2019

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	An October, 2019 physician order report, dated 10/1/19 to 11/1/19, indicated the resident was on a pureed diet in a divided plate and nectar thick liquids in a 2 handled cup. The record lacked documentation for built-up eating utensils nor a care plan for dental care/cleaning of the resident's dentures. A resolved ADL (activities of daily living) Functional/Rehabilitation potential care plan, initiated on 8/2/16 with a goal target date of 5/12/19, indicated the resident would be able to eat and drink with staff assistance if required, at all meals with interventions included, but not limited to, insert dentures prior to meals, dental evaluation and intervention as needed, and observe for changes and notify physician for further orders. A SSD progress note, dated 10/30/19 at 12:17 p.m., indicated the SSD had been made aware of Resident 17's bottom denture missing, notified family, and scheduled a dental appointment for 11/21/19 for the resident. On 10/30/19 at 11:19 a.m., SSD provided and identified as a current facility policy, dated 4/23/19, titled "Grievance/Concern Process," which indicated, "...Purpose: To establish a process for responding to a resident or resident representative to resolve grievances a resident may have...Upon identification of a resident or resident representative concern, complete the grievance/concern form identifying the issue and forward the form to the Grievance Officer...." 3.1-24(a)(3)		follow-up and to schedule a Dental Appointment as appropriate. Step 4 The Director of Nursing or designee will perform Quality Assurance Review via interviews with residents, families and staff; to ensure residents with lost or broken dentures have appropriate follow-up weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	

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F 0842 SS=D Bldg. 00	483.20(f)(5); 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral			

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	directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure a death event was documented in the resident's medical record for 1 of 1 residents reviewed for death (Resident 52). Findings include: Resident 52's record was reviewed on 10/31/19 at 1:48 p.m. The resident's medical record lacked	F 0842	It is the Policy of Exceptional Living Center of Brazil to ensure a death event is documented in the resident's Medical Record. Step 1 Resident 52 no longer resides at the facility. Step 2 No other residents were affected by this citation.	12/04/2019

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	documentation of when and what observations and services were provided by nursing staff when the resident passed away. The last progress note observed in the resident's medical record was, dated 8/18/19 at 7:07 p.m., and indicated the resident had been resting comfortably in bed. A hospice visit note report, dated 8/20/19, indicated the resident was discharged due to having expired (passed away). A hospice communication tool, dated 8/10/19, indicated the medical director/hospice team physician certified the resident had a prognosis of 6 months or less if the disease process ran its normal course. A care plan, start date 8/10/19, indicated the resident required hospice related to end of life care secondary to heart disease. During an interview, on 11/1/19 at 9:01 a.m., the Director of Nursing (DON) indicated she had spoke with two nurses that were on duty when the resident passed away and because it was shift change neither one had documented on the event. She indicated at least one of them should have documented in regards to the resident passing away and what observations and services were provided. On 11/1/19 at 10:39 a.m., the DON provided a policy, dated 12/26/16, and titled, "Documentation in the Clinical Record," and indicated it was the policy currently being used by the facility. The policy indicated, "Purpose: Guidelines for documentation...Procedure: 1. Observations...services performed, etc., are		The facility will ensure documentation is completed in the event of a resident's death as appropriate. During the Morning Clinical Meeting the Clinical Interdisciplinary Team will review the Medical Records of a residents who has passed to ensure the documentation was completed as appropriate. Step 3 Licensed Nurses were re-educated to ensure a death event is documented in the resident's Medical Record. Step 4 The Director of Nursing or designee will perform Quality Assurance Review to ensure a death event is documented in the resident's Medical Record with each death. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director and the Quality Assurance Performance Improvement Committee with each occurrence.	

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	documented in the resident's clinical records...3. Incidents/Events, accidents, or changes in the resident's condition will be recorded....5. Documentation of procedures and treatments may include...g. The signature and title of the individual documenting." 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure hand sanitation was completed before handling medications and before and after direct contact with residents for 3 of 5 resident's reviewed for medication administration (Resident 13, Resident 28, and Resident 202). Findings include: During a medication administration observation, on 10/31/19 at 8:38 a.m., Registered Nurse (RN) 8 was observed to prepare and administer Resident 13's medications. RN 8 did not perform hand hygiene before handling medications and before or after direct contact with the resident. During a medication administration observation, on 10/31/19 at 8:43 a.m., RN 8 was observed to prepare and administer Resident 28's medications. RN 8 did not perform hand hygiene before handling medications and before or after direct contact with the resident. While in the resident's room she applied the resident's nasal canula to her nostrils, and administered restasis eye drops to both eyes. She did not wash her hands or apply gloves prior to either administration. During a medication administration observation, on 10/31/19 at 9:03 a.m., RN 8 was observed to prepare and administer Resident 202's medications. RN 8 did not perform hand hygiene before handling medications and before or after direct contact with the resident. During an interview, on 10/31/19 at 9:25 a.m., RN 8 indicated she should have washed her hands prior	F 0880	It is the Policy of Exceptional Living Center of Brazil to ensure hand sanitation is completed before handling medications and before and after direct contact with residents. Step 1 Residents 13, 28 and 202 were assessed by the Director of Nursing or designee and showed no signs or symptoms of infection related to the potential of improper hand hygiene during the medication pass. Registered Nurse (RN) 8 no longer resides at the facility. Step 2 No other residents were affected by this citation. A Nurse Manager will observe for proper hand hygiene during the Medication Pass observations with each Licensed Nurses annually to ensure he/she is utilizing proper hand hygiene during the medication pass. Step 3 Licensed Nurses were re-educated on proper hand hygiene during Medication Pass to include washing hands proper to starting the medication pass and between each resident if his/her hands make contact with the resident or anything the resident has touched. The Licensed Nurse can use hand sanitizer between residents (no more than three	12/04/2019

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	to the administration of eye drops and worn gloves during the administration but had forgotten to do so. During an interview, on 10/31/19 at 10:52 a.m., the Staffing Development Coordinator (SDC) indicated staff should wash hands or apply hand sanitizer prior to and after the administration of medications. Gloves should be worn when there was the potential for exposure to mucous membranes and should have been worn when administering eye drops. On 10/31/19 at 11:11 a.m., the Corporate Consultant provided a policy, titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices...Procedure: ...11. Cleanse hands before handling medications and before and after direct contact with residents...24. Gloves should be worn when there is a potential for exposure to resident's blood, excretions, secretions, open wounds, or mucous membranes...." 3.1-18(b)(1)		times) as long as hie/she has not come into contact with any wet substances or visible soil-age. Step 4 The Director of Nursing or designee will perform Quality Assurance Review during Medication Pass observations to ensure proper hand hygiene 1-3 times weekly for four weeks then weekly for four weeks then monthly. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director weekly and the Quality Assurance Performance Improvement Committee monthly.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 28, 29, 30, 31, and November 1, and 4, 2019. Facility number: 000514	R 0000	Submission of this Plan of Correction does not constitute an admission that a deficiency exists or was cited correctly. This Plan of Correction is being submitted to meet State and Federal requirements.	

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	Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.			
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation, and interview, the facility failed to ensure the most recent annual survey and any plan of correction were readily accessible and posted. This had the potential to effect 28 of 28 residents. Findings include: On 11/4/19 at 9:20 a.m., during an initial tour of the facility, the State Survey book had a 2567 PSR (post survey revisit) to the annual for 2018, but the 2567 annual survey report with the plan of correction, dated 10/1/18, was not in the book. On 11/4/19 at 12:50 p.m., the Executive Director (ED) indicated, he realized the 2567 annual survey report was not in the binder. He had had a lot of employee turnover and the State Survey book had just gotten overlooked. The facility did not have a written facility policy for posting the survey reports, but followed the State regulations.	R 0042	It is the Policy of Exceptional Living Center/Towne Park Assisted Living of Brazil to ensure the most recent survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys are posted per regulation. Step 1 Most recent survey was posted during the survey. Step 2 The Executive Director or designee will review the public survey binder, that contains past surveys, to ensure surveys are posted per regulation, quarterly. During resident council, residents were informed of the location of the public survey binder that contains past surveys. Step 3 The Executive Director has been educated by the Vice President of Clinical Services to ensure the	12/04/2019

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			survey is posted per regulation. Step 4 The Vice President of Operations or Clinical Services or designee will perform Quality Assurance Review to ensure public survey binder is posted per regulation, quarterly . Areas of concern will be addressed immediately. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly.	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure a residents annual health statement was completed and signed by the physician yearly after admission for 1 of 7 residents reviewed for annual health statements (Resident 120). Findings include: Resident 120's record was reviewed on 11/4/19 at 2;15 p.m. The resident was admitted to the facility on 6/20/16. The record lacked documentation of annual health statement that included the resident was free of communicable diseases including tuberculosis in the infectious state. During an interview, on 11/4/19 at 2:30 p.m., the Director of Nursing (DON) indicated she did not	R 0409	It is the policy of Exceptional Living Center/Towne Park Assisted Living of Brazil to ensure each resident has a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Step 1 The Health Statement for resident #120 has been completed. Step 2 Current facility residents Physician's orders were reviewed to ensure that each resident has a	12/04/2019

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	find a current annual health statement for the resident. During an interview, on 11/4/19 at 2:43 p.m., the Executive Director (ED) indicated they do not have a specific policy for the annual health statement but would follow regulations. The Indiana Residential Regulation, dated 2008, 410 IAC 16.2-5-12(d), indicated...(d) prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter...."		Health Statement completed within the last year. The Director of Nursing will complete a quarterly review during monthly review of orders to ensure residents have an annual health statement. Step 3 The Vice President of Clinical Services educated the Director of Nursing on the requirement of having an annual Health Statement on each resident. Step 4 The Executive Director or designee will perform Quality Assurance Review to ensure each resident has a Health Statement completed. This will be conducted quarterly. Areas of concern will be addressed immediately.	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection			

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EXCEPTIONAL LIVING CENTER OF BRAZIL	501 S MURPHY AVE BRAZIL, IN 47834

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	with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the failed to ensure a purified protein derivative (PPD) test (a skin test to detect tuberculosis) was completed on admission to the facility for 2 of 7 residents reviewed for PPD testing (Residents 130 and 131). Findings include: 1. Resident 130's record was reviewed on 11/4/19 at 12:53 p.m. The resident was admitted to the facility on 8/14/19. The clinical record lacked documentation the resident received a purified protein derivative (PPD) test (a skin test to detect tuberculosis) since admission. A PPD testing document indicated the resident received PPD testing on 10/2/18 and 10/9/18, at the facility where she previously resided. Both tests were negative. 2. Resident 131's record was reviewed on 11/4/19 at 1:15 p.m. The resident was admitted to the facility on 8/14/19. The clinical record lacked documentation the resident received a purified protein derivative (PPD) test (a skin test to detect tuberculosis) test since admission. A PPD testing document indicated the resident received a 2nd step PPD testing on 10/9/18, at the facility where he previously resided. The test was negative. On 11/4/19 at 2:45 p.m., the Director of Nursing (DON) provided a copy of a 2nd step PPD from the resident's previous facility. At the same time,	R 0410	It is the policy of Exceptional Living Center of Brazil to ensure each resident has completed a tuberculin skin test within three months prior to admission or upon admission. Step 1 Resident 130 and 131 no longer reside at the facility. Step 2 Current facility residents were reviewed to ensure Tuberculin skin tests were completed as appropriate. Director of Nursing will review new admissions to ensure Tuberculin skin test where administered and read as appropriate. The Director of Nursing will review the residents record to ensure yearly Tuberculin skin test are given during annual Level of Care evaluation. Step 3 Licensed Nurses were re-educated to ensure Tuberculin skin tests are completed per regulation. Step 4 The Director of Nursing or designee will perform Quality Assurance Review to ensure each resident has Tuberculin skin test per regulation. Areas of concern will be addressed immediately.	12/04/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155503	A. BUILDING 00 B. WING	11/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	the Executive Director (ED) indicated they did not have a policy on PPD testing, but followed the state guidelines. The Indiana Residential Regulation, dated 2008, 410 IAC 16.2-5-12 (e)(f), indicated..."(e)...a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours...(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method...."		Findings will be reported to the Executive Director following quarterly review.	